CIGNA Choice Fund® Consumer Driven Health Plan Claim Form
HRA & Healthy Awards

For assistance with filling out the claim form, please see page two.

CIGNA®

FOR INTERNAL USE ONLY:
CORR TYPE - RD

EMPLOYEE INFORMATION (*Indicates Required Fields)

*1. CIGNA ID NUMBER OR SOCIAL SECURITY NUMBER	*2. LAST NAME	*3. FIRST NAME	*4. M.I.	*4a. DATE OF BIRTH

*5. MAILING ADDRESS	*6. CITY	*7. STATE	*8. ZIP CODE

9. DAYTIME TELEPHONE NUMBER	10. E-MAIL ADDRESS	11. EMPLOYER NAME	*12. ACCOUNT NUMBER(S)
		State Health Benefit Plan ACTIVES	**3330877**

PATIENT INFORMATION

*13. PATIENT NAME *(Last, First, M.I.)*	*14. PATIENT DATE OF BIRTH

ITEMIZED CHARGES

*15. DATE OF SERVICE (MM/DD/YY)	*16. AMOUNT TO BE REIMBURSED	*17. TYPE OF SERVICE 1 = Medical 35 = Dental 88 = Pharmacy 89 = Over the Counter Items AL = Vision 81 = Routine Care/Physicals A4 = Mental Health/Substance Abuse 12 = Incentives 30 = Premiums 9 = Other	*18. DESCRIPTION OF SERVICE	19. NDC Code *(Optional)*	20. DIAGNOSIS *(Optional)*	*21. PROVIDER NAME

PAYMENT INFORMATION

Payment will be sent to the member unless box 22 is checked. If box 22 is checked, payment will be made to the provider. When electing to pay the provider, boxes 22 through 28 must be filled out.

22. PAY BENEFITS TO:	23. PROVIDER NAME	24. PROVIDER IDENTIFICATION NUMBER: *(Please select)*
☐ Provider		☐ TIN _____ ☐ SSN _____

25. PROVIDER MAILING ADDRESS	26. CITY	27. STATE	28. ZIP CODE

For Health Care Claims: I certify that all expenses for which reimbursement is claimed from the CIGNA Health Reimbursement Account have been incurred and have not been reimbursed and are not reimbursable under any other health plan. I understand that I am required to submit, in addition to this claim form, an itemized receipt from a merchant. I represent that any individual (other than the employee or employee's spouse) for whom a claim is filed hereunder, qualifies as a dependent of the employee for federal income tax purposes. I further declare that I have not and will not deduct these expenses from my federal, state or local income tax returns.

*29. EMPLOYEE SIGNATURE *(Required - unsigned Reimbursement Request Forms will not be considered for reimbursement)*	DATE

Please send or fax completed form along with all required documentation to:

CIGNA HealthCare Choice Fund®
P.O. Box 188050
Chattanooga, TN 37422-8050
Member Services: 1-800-633-8519

Cat. #828161 02/2009

GENERAL CLAIM SUBMISSION GUIDELINES

- Only one patient per claim form.
- Claim must be submitted with itemized receipts or EOB. If submitting a receipt, the receipt must detail the date of service, provider name and address, services rendered and the amount due. Prescription claims must include the actual Rx pharmacy receipt, to include the NDC number.
- Cash register receipts are only acceptable for over the counter items.
- Do not use a highlighting marker when filling out this form.
- Please send or fax completed form along with all required documentation to:

CIGNA HealthCare Choice Fund®
P.O. Box 188050
Chattanooga, TN 37422-8050
Member Services: 1-800-633-8519

INSTRUCTIONS FOR FILLING OUT THE CLAIM FORM

All fields with an * are required fields. Please fill out all the * fields to ensure timely processing of your reimbursement claim. Indicating "See Attached" or "N/A" will result in a delay in the processing of the reimbursement claim.

ITEMIZED CHARGE SECTION

- **Box 15: Date of Service** - This field should be populated with the date that you obtained/purchased the services at the doctor/hospital/pharmacy, etc.
- **Box 16: Amount to be Reimbursed -** This field should be populated with the dollar amount that you are seeking reimbursement for.
- **Box 17: Type of Service** - From the listed items, please choose the one that identifies the service you are seeking reimbursement for. If there is no item listed specific to your claim type, please select Other.
- **Box 18: Description of Service** - This field should be populated with a description of the services you obtained at the doctor/hospital/pharmacy, etc. IE: Office Visit, X-Ray, Lab Work, Prescription. For over the counter items, please list the item name. IE: Tylenol, Cough Syrup, Contact Solution, etc.
- **Box 19: NDC Code** - This is an optional field. This is a 11 digit code that may or may not be listed on your pharmacy receipt.
- **Box 20: Diagnosis** - This is an optional field. Should you choose to fill it out, you should indicate the reason why you went to the doctor or hospital. IE: Sinus Infection, Earache, Flu, etc. For certain services, this information is needed in order to process your reimbursement claim. Filling out this field will allow us to process your reimbursement claim in a timely fashion.
- **Box 21: Provider Name** - This field should be populated with the name of the provider that you obtained the services from. IE: Dr. John Smith, St. Joseph's Hospital, Walgreen Pharmacy, etc.

PAYMENT INFORMATION SECTION

All payments will be made to you unless you choose to have the payment sent directly to the provider of service. If payment is to be made to the provider, then you must fill out boxes 22-28. The information for boxes 22-28 can be found on a copy of the bill that the provider of service has given to you.

Payment Guidelines: Only one individual, whether member or provider of service, can be paid per claim form. If more than one individual is to be paid, a separate claim form for each payee must be completed.